



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-11-2179-01

MFDR Date Received

March 1, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our doctors usually spend 25-30 minutes conducting a re-evaluation of established patients. As noted is the typed subsequent report that was submitted with the HCFA billing, you can clearly note that a comprehensive history is documented under Present Medical Condition on our follow-up exam form. A comprehensive examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of moderate complexity as also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medications and referral recommendations."

Amount in Dispute: \$171.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider's office visits notes for procedure 99214 do not support the level of service billed. It requires 2 key components: 'Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.' The notes do not appear to have 2 components mentioned above and therefore, no additional payment is recommended at this time."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2010	99214 and 99080	\$171.00	\$1.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.4 sets out the general rules for Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.
3. 28 Texas Administrative Code §129.5 sets out the general rules for Work Status Reports.
4. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
- 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed
- 45 – Charges exceed your contracted/legislated fee arrangement
- 193 – Original payment decision is being maintained. This claim was processed properly the first time
- 5081 – Reduction or denial of payment resulting after a reconsideration was completed

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the insurance company issue payment for CPT code 99080-73 pursuant to 28 Texas Administrative Code §129.5?
3. Did the requestor submit documentation to support the billing of CPT code 99214?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on March 30, 2011 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §129.5 "(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."
The requestor seeks reimbursement for CPT code 99080-73 rendered on September 10, 2010. Review of the DWC-73 supports that requestor completed the DWC-73 as required by 28 Texas Administrative Code §129.5. Review of the EOB dated October 13, 2010 documents that the insurance carrier issued payment in the amount of \$13.50 for CPT code 99080-73. Therefore additional reimbursement is recommended in the amount of \$1.50.
3. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor seeks reimbursement for CPT code 99214 rendered on September 10, 2010. The AMA CPT Code book definition of CPT code 99214 is as follows "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family." Review of the documentation titled "Follow-up Evaluation" does not meet the documentation requirement for billing CPT code 99214, as a result, reimbursement for CPT code 99214 cannot be recommended.

4. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement for CPT code 99080-73.

Conclusion

For the reasons stated in F&D, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$1.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

October 17, 2013

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.